

Telehealth During COVID-19

Advantages, Challenges, and Barriers Across Zero to Three Programs

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Abstract

The COVID-19 pandemic threw a spotlight on telehealth as a mechanism for programs and professionals who provide direct services to young children and families to be able to continue essential supports and services. Providers, agencies, and insurance companies had to rapidly evolve in order to reach families and other caregivers in new ways. This article describes how four different programs in Louisiana took action to ensure, as best as possible, the continuation of mental health services to children and families during an unprecedented global pandemic.

In the spring of 2020, with the coronavirus pandemic gripping the nation, Louisiana required its citizens, with the exception of essential personnel, to quarantine in their homes. This unprecedented move was designed with the goal of “flattening the curve” (the attempt to slow the rising number of new virus infections) as Louisiana experienced staggering rates of COVID-19 infection, hospitalizations, and deaths. While the choice was difficult, it was necessary to save lives; however, the resulting effects on the provision of health and mental health services were dramatic and required immediate action to ensure access to and continuity of care.

The COVID-19 pandemic has impacted all areas of health care requiring adjustments to how care is provided while simultaneously protecting patients, providers, and staff from the spread of the novel coronavirus. Prior to COVID-19, telehealth services were growing nationwide due to a well-documented shortage of mental health providers especially for children in the birth to 5 years age range and their caregivers. The COVID-19 pandemic thrust telehealth into the forefront, challenging providers, agencies, and insurance providers to rapidly change and implement plans to reach families and other caregivers in new ways. The four programs described in this article experienced the issues, challenges, and success (to the extent possible under extraordinary circumstances) of working to ensure the continuation of mental health services to children and families.

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Implementation of Child–Parent Psychotherapy in a Virtual Setting

Joy D. Osofsky

Now more than ever, during the COVID-19 pandemic it is crucial to adapt training and medical services and therapy to meet the needs of young children and families. The Louisiana State University Health Sciences Center (LSUHSC) Harris Center for Infant Mental Health year-long training program for psychology pre-doctoral interns, post-doctoral fellows, and child psychiatry fellows is providing training and supervision virtually. The training program also includes virtual training in child–parent psychotherapy (CPP) as well as exposure to other evidence-based treatments for young children and families. To carry out assessments and therapeutic services successfully, there are a number of steps that are necessary for virtual work that may not always be included for in-person services.

Because COVID-19 affects everyone—both the client/patient and therapist—clinicians must be aware of and reflective about the impact of COVID-19 on everyone. For clinicians working virtually using telehealth for the first time, delivery of services can seem different in several ways. First, for many clinicians, working from home rather than an office or clinic is likely a different experience. For clinicians who also have their own children at home, in addition to seeing patients, they must manage child care, virtual home schooling, and care for others at home. Therefore, it may be difficult at times for them to provide time and place for uninterrupted services. In addition, they may personally be impacted by COVID-19 by having family members ill or even some who have died. In addition, they are separated from family and friends and the usual supports in their lives. They may also be working in hospital settings or other COVID-19–related settings.

Reflective processing for clinicians is a crucial part of providing young child and family treatment, and it needs to be an ongoing part of the work during COVID-19. Further, it is important to engage parents/caregivers and children virtually as dyadic observations are essential for understanding and providing treatment for young children and families. A critically important issue that needs to be addressed and resolved is the fact that many families for whom clinicians provide services do not have Internet connectivity or access to computers or other equipment necessary to participate in telehealth appointments with their young child.

While parental guidance can be provided by telephone, dyadic CPP requires being able to either be with or observe the parent/caregiver and child together. In understanding effective ways to provide dyadic treatment virtually and implementing CPP using telehealth, it may be helpful to consider long-accepted knowledge from the infant and early child mental health field related to interactions between infants and caregivers including those with more adversities and other high-risk circumstances. Brazelton, in his Touchpoints model (1992), stated that clinicians working with at-risk infant–caregiver dyads need to recognize



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For clinicians who also have their own children at home, in addition to seeing patients, they must manage child care, virtual home schooling, and care for others at home.

and “value disorganization.” Tronick & Beeghly (2011) have described this idea as the “messiness” that may emerge in typical interactions.

Another consideration for clinicians is that they may have more difficulty observing parent/caregiver–child interactions virtually when compared to the controlled situation in the playroom, which can lead to increased anxiety for both the clinician and the parent. The dyadic interactions that the clinician is able to observe virtually may be unpredictable and at times difficult to understand. However, if the clinicians can bear in mind the idea of “meaning making” (Tronick & Beeghly, 2011), it may aid in understanding what they may observe in the interaction. These more naturalistic interactions observed in home situations may be important in helping the infant and young child get back on a developmental track and in supporting the relationship. With virtual CPP, clinicians may be observing many such meaning-making interactions. However, they can be further complicated by anxiety related to COVID-19 leading to increased stress at home. With those families who have Internet access and who have a computer or tablet for a virtual therapy session, there are many creative approaches that therapists can use to engage young children and parents in CPP using a virtual platform.

Because CPP is not a directive type of therapeutic treatment, clinicians depend on observations. The team at LSUHSC has developed an operational scale, “What to Look for in the Relationship” (Osofsky et al., 2019), that has been helpful for teaching and training about how to observe the relationship during dyadic play. The team has found it to be extremely helpful to guide observations and understand interactions

between parents/caregivers and young children when doing CPP virtually. Clinicians should also recognize that many parents experienced virtual CPP as very supportive during COVID-19. The process allowed them to reflect on experiences that have occurred in the past, help handle their emotions, recognize the normalcy of their current feelings, and anticipate improvement in the future. It provides an opportunity for the dyad together with the therapist to experience the “new normal” in their lives and CPP treatment.

A “silver lining” that many clinicians have noted working virtually with parents and caregivers and young children is that it is easier to provide parental guidance by arranging separate meetings with the parent or, when children are a little older, to speak with them for a short time after each session while the child plays for a few minutes in another room. The time spent with parents is particularly important during COVID-19 to listen and provide additional support during stay-at-home orders with preschools and child care centers closed. The connection can also help provide the support that parents need to identify “angels in the nursery” moments, referring to the transmission of benevolent influences on parenting (Lieberman et al., 2005) including making connections with their child, remembering positive emotions from the past, and feeling hopeful about the future despite the current uncertainty due to COVID-19.

Interventions With CPP That Work via Telehealth

Depending on the situation at home, virtual CPP provides a time that the parent and child can be together playing, which may be difficult or not often thought about with the chaos and uncertainty related to COVID-19. Some CPP clinicians have helped parents or caregivers recognize that ordinary items in their homes, such as boxes, can be made into play materials (P. Stepka, personal communication, May 5, 2020). Reading books or using a method developed by retired judge Constance Cohen, described as the 2-4-2 book sharing strategy (Cohen, 2020), is widely used in child welfare to help the parent keep a close relationship with her young child in out-of-home care while also supporting development.

Difficulties and Barriers for Doing Virtual CPP

Technical difficulties can interfere with opportunities to do CPP virtually for those families who do not have tablets or computers or consistent Internet connectivity. For parents, particularly those with many work responsibilities and other children, it may be difficult to find time or private space at home to participate in CPP treatment. Further, some parents

are not comfortable with the clinician seeing their home. Clinicians also report more difficulty doing assessments online, gathering background and current information that includes traumatic events for the parent or child which they may be less comfortable sharing virtually. Further, safety for the mother and child must always be considered and, given the increase in child abuse, child neglect, and alcohol and drug use, a parent may be hesitant to report on negative events on a virtual call.

Despite the difficulties and barriers, it is important to recognize that a virtual connection may offer more support at a time when there is a need for social distancing and other restrictions. There can be meaningful relationships developed virtually, and they are especially helpful when in-person relationships are limited.

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Tulane Infant and Early Childhood Consultation Supports and Services (TIKES)

Angela W. Keyes and Allison Boothe Trigg

The Tulane Infant and Early Childhood Consultation Supports and Services (TIKES) model is designed to assist all children, staff, and families involved in early childhood education programs with the goal of achieving healthy behavioral, social, and emotional development for young children. The TIKES program has consistently served the Louisiana early childhood education community since 2007. TIKES has three main goals: (a) to promote the social and emotional health of young children, (b) to support teachers'/caregivers' promotion of healthy child development, and (c) to refer for treatment and/or design interventions for young children exhibiting behavioral or developmental concerns. TIKES merges child-centered consultation and program-centered consultation to allow teachers, directors, and caregivers to assist individual children who may need extra support or outside referrals while also allowing consultation to focus on the early childhood education program as a whole and how factors specific to these programs impact the social-emotional development of the children enrolled there.

TIKES mental health consultants are licensed or license-eligible mental health professionals who serve a varied case load of early childhood education programs, visiting weekly or every other week depending on the site's size. Those centers that accept publicly funded children and family child care homes that participate in Louisiana Department of Education (LDOE) funded pilot projects were eligible for services in the 2019–20 fiscal year. Priority is given to sites with a demonstrated need on the basis of quality ratings (i.e., sites designated as unsatisfactory or approaching proficient in the Louisiana rating system are prioritized). Consultants provide consistent follow-up visits to providers who have participated in mental health consultation (MHC) previously and connect with members of their regional networks, including coaches, technical assistants, and others to support coordination of services. All consultants are provided ongoing individual and group reflective supervision to support their work with providers.

During a consultation visit, a consultant may spend time on any of the following:

- observing in the classroom;
- meeting with an individual teacher, groups of teachers, a director, and/or an owner regarding children, program operation, or other concern;
- conducting didactic group meetings on various topics pertaining to early childhood development and mental health;
- meeting with parents;



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An added complication of teleMHC involved the limitations inherent in remote service provision, such as an inability to see any more than what the caregiver allows and the difficulty in reading nonverbal cues that would ordinarily be more apparent during a face-to-face encounter.

- designing a behavior plan for a particular child (with parent consent);
- conducting parent workshops on various early childhood topics;
- completing screening measures to support children with developmental or mental health concerns (with parent consent);
- making referrals to community agencies for more in-depth services when needed;
- and/or various other activities.

Meeting the Needs of Children, Caregivers, and Families During the COVID-19 Pandemic

Before the initial quarantines were initiated, but as COVID-19 began to make headlines, TIKES leadership started planning how to provide services and support to the early childhood community during what was sure to be a difficult and unusual time. As TIKES had a cohort of trained infant and early childhood mental health professionals, TIKES leadership asked the program funders, LDOE, what else could be done to support the early childhood community if programs closed. LDOE agreed to fund TIKES to provide MHC using a virtual platform. This "teleMHC" model would allow TIKES to provide supports to teachers, parents, grandparents, and child care resource and referral personnel who needed additional assistance related to their care of young children. In addition, as programs began to

voluntarily close and respite centers opened to provide child care for frontline workers and first-responders, TIKES realized that it would need flexible options to find members of the early childhood community in need and determine how to meet those needs given the restrictions of quarantine.

Before TIKES could begin providing teleMHC, it was necessary to develop and build an infrastructure to support service provision, including a means for requesting services, a platform for providing services, and informing the early childhood community of these services. The state shut down quickly in response to the COVID-19 pandemic. Thus, concerns loomed about continuation of services, which had historically been provided in person, so swift action needed to be taken to initiate services in a virtual format that could be used by consultants who all worked for different subcontractor agencies across the state.

TIKES leadership immediately identified a virtual platform for service provision as well as a mechanism by which caregivers could request services. A link was created on the TIKES website that allowed caregivers to request services. TIKES leadership then assigned the request to a consultant in the same region of the state, who would be more familiar with referral options in their community. A shared calendar allowed staff to check availability of consultants when assigning requests. Because it was necessary to use a platform that allowed for protection of personal health information, TIKES investigated several options that would allow for the continuation of services via a HIPAA-compliant platform where accounts could be created by a number of unique users and that also would be cost effective. After a platform was selected and activated, consultants were able to create accounts that allowed them to interact face-to-face with caregivers to provide virtual support and referrals. Concurrently, the administrators and consultants began advertising the teleMHC service via individual contacts with existing providers, reaching out to child care resource and referral agencies, as well as sending email blasts to parent groups and posting messages on agency and program social media pages.

Although the infrastructure planning was demanding, teleMHC services were offered in less than 2 weeks. As requests were received, consultants also made direct contacts with a number of individuals, including parents, teachers, and owners/directors of centers and family child care providers via telephone and e-mail. Because the work overwhelmingly involved face-to-face onsite service provision, the quick transition to teleMHC required the consultants—who were accustomed to sitting with caregivers while discussing concerns, challenges, or successes—to pivot. Using a virtual format necessitated a greater focus on building rapport early, especially for parents and providers not otherwise eligible to receive MHC services, who would typically have a few sessions with the consultant before being referred to a resource in their communities.

An added complication of teleMHC involved the limitations inherent in remote service provision, such as an inability to see anything more than what the caregiver allows and the difficulty

in reading nonverbal cues that would ordinarily be more apparent during a face-to-face encounter. For example, with in-person consultation, a consultant meets with a caregiver to discuss concerns about a child's behavior, then follows up with an in-class observation of the child. In the teleMHC model, consultants are unable to directly observe children and are dependent on their caregivers to report concerning behaviors, which increases the complexity, and potentially the level of difficulty, involved in determining the best course of action. Similarly, when providing remote services, it is difficult to know who else may be able to hear the conversation. Consultants have learned to be sensitive to this aspect of the interaction, understanding that clients may be less comfortable sharing information over remote contacts due to concerns that someone else, such as a co-worker or family member, may be listening. This concern has been especially evident when working remotely with parents. It has been important for consultants to work to schedule remote contacts for a time when the caregiver has privacy, as these conversations may include direct discussion of concerns the caregiver has about the child or themselves. The consultant must work to support the caregiver in understanding this, while also striving to provide support and/or referral information, recognizing that there may not be another contact in which to do so. For example, a consultant had been working with a teacher who had recently left a relationship that involved domestic violence. The consultant had provided community referral and support information for the teacher, but the teacher was not able to be as forthcoming with the consultant during conversations after remote consultation began due to privacy issues.

An additional concern was the ability to report suspected child abuse or neglect during remote consultations, especially if the client did not agree to provide a physical address. TIKES leadership discussed these concerns with child abuse hotline administrators in the Louisiana Department of Child and Family Services and worked out a plan to alert the hotline administrators directly with any and all identifying information when this situation arose.

A final challenge experienced in the transition to teleMHC services consisted of equity issues in access to services. The TIKES consultation program prioritizes services to early childhood education programs that serve children who receive a state subsidy, those in the child protection system, and programs identified as needing additional support to meet quality standards. With this focus, families may be from lower socioeconomic backgrounds. Moreover, because teachers are historically underpaid for the care they provide, teachers may also fall into lower socioeconomic groups. As a result, many caregivers lack access to computers, other than a mobile telephone, and lack high-speed Internet service in their homes. Because services could only be provided virtually, teachers lost easy access to needed consultation services, which would provide an outlet for them to discuss concerns, worries, and stresses as they transitioned to being quarantined. When

necessary, consultants made contact by telephone, which is certainly helpful, but not always an adequate substitute for in-person visits or even video contacts.

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Louisiana State University Health Sciences Center Infant Team

Amy B. Dickson

In the age of social isolation due to COVID-19, the relationship between children in foster care and their biological family members has been deeply affected. Concerns regarding the spread of the virus led many child protection agencies to cease all in-person visits between children in foster homes and their biological parents. Most jails and prisons shut down visits with incarcerated parents, and foster children also lost visits with their siblings. There was understandable concern that children's biological parents may not be social distancing and could expose their children to COVID-19, who could then affect their foster families, many of whom contain older caregivers. Child protection caseworkers often have to transport and supervise during the visits, which would also expose the caseworkers. For the youngest children in foster care, telephone calls or even video visits are difficult. In addition, courts around the country did not have a unified response to handling dependency court cases in a pandemic. It took many courts some time to get hearings up and running virtually, which delayed adoptions, terminations, and reunifications, leaving numerous children and their caregivers in limbo. In Louisiana, there was no unified consensus, and there were different rules about visitations and court hearings in each parish.

The Louisiana State University Health Sciences Center (LSUHSC) Infant Team works with children from birth to 6 years old in foster care in several parishes throughout the state. The Infant Team works closely with child protection caseworkers and other providers for the family to assess the child's relationships with all caregivers. The Infant Team then works to remediate the deficits that brought the child into state custody



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Concerns regarding the spread of the virus led many child protection agencies to cease all in-person visits between children in foster homes and their biological parents.

through individual treatment with the parents, child-parent psychotherapy (CPP) with the child and their biologic parents, and in separate CPP sessions with the child and their foster caregivers to support that placement in meeting the child's needs. The Team routinely writes forensic reports, has team staffings with attorneys, DCFS caseworkers, court-appointed special advocates, and other professionals involved in the

case, and testifies in court to help move the child safely to permanency in a timely fashion.

The possible spread of COVID-19 presented a legitimate legal and medical risk, and almost all child protection agencies stopped in-person visits between parents and their children. For the youngest children this change involved switching to telephone visits or video visits. Young children do not retain interest in a telephone call even when placed in speakerphone mode. Some parishes in Louisiana rushed to provide parents with cell phones capable of video chatting capabilities, while other parishes struggled with obtaining and dispersing phones. Families in rural parishes often did not have access to reliable Wi-Fi and so could not effectively use their new cell phones. An added complication was that young children cannot be unattended during the visitation and so foster parents were placed in the awkward position of needing to facilitate visits with the biological parents. There was an added layer of complication in facilitating for foster parents who did not speak biological parents' preferred language. For young children who wanted to see their parents, some visits went well. However, many biological parents, especially those new to CPP or parenting classes, were ill prepared to engage their young children over the phone. Parents would give up and end the call early when the child walked off or did not respond to their many questions.

The Infant Team also began work with incarcerated parents who had been released early to reduce the prison population given the proliferation of COVID-19 in those settings. Once released, some of these parents were attempting to build a relationship with their young child whom they had never seen or had not seen in some time. Building or maintaining a relationship or a secure attachment over video calls is obviously challenging. Parents who remained incarcerated often did not have access to the telephone to call at a time that worked for their child (e.g., they would call at nighttime, nap time, when the children were in child care). Not all prisons waived fees for the calls, and the foster parents were placed in an uncomfortable position of having to accept or not accept the call and pay for any charges or fees. These virtual visits placed the foster parent as the supervisor during the video chat or telephone call.

Numerous foster parents expressed frustration at having to conduct therapy at home, supervise visits, and meet all of their foster children's needs while also working full time from home and assisting with older children's homeschooling. Foster parents were distressed at having no end in sight, and many biological parents began contacting foster parents directly to speak to their children, adding another layer of stress. In addition, some families did not want the clinician to have video access to their home and these families resisted attending sessions, or turned their video off, making it much more difficult to read the client's mood and assess their functioning.

Foster families had to adjust to conducting therapy in their home which, in addition to privacy issues, required finding the appropriate venue and necessary toys, and working with a therapist who was on screen instead of in-person.

The interruption of the in-person visits is also being addressed in termination hearings, with some parents claiming that the lack of access to their children was the reason why they have not completed their case plans. While many service providers (e.g., domestic violence, substance abuse, therapy) have moved to virtual platforms, parents have claimed difficulty attending and advocated for more time to meet the goals in their case plans. The increasing length of the court case has been draining for foster parents.

Not all news was bad. Many of the young children with attachment issues were able to settle into their relationships with their foster parents and thrived on the continuity of being in the same environment each day with stable caregivers. Children who previously struggled behaviorally due to the inherent disruption of family visits became calmer when the visits stopped. Foster parents could address any behavior challenges and emotional needs immediately after a video visit because the children stayed with their foster parents versus returning to child care. Adoptions have been conducted via video chat, with numerous families and friends attending, court cases eventually began to proceed, and providers increased their flexibility and resourcefulness to provide needed services to their families.

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Louisiana State University Behavioral Science Center Outpatient Services

LaKisha Y. Mamon

The Louisiana State University Behavioral Science Center (LSU BSC) offers a full spectrum of outpatient services for infants, children, and adults. Services include intake and assessments completed by a multidisciplinary team of providers, including social workers, psychologists, and psychiatrists. The LSU BSC is also an educational center for clinical mental health providers through training programs for Harris Center for Infant Mental Health, child and adolescent psychiatry, general psychiatry, psychology, and social work. The clinic and programs are unique in their interdisciplinary approach to mental health. Providers use evidence-based care guided by the current research and can include a combination of psychotherapy and medication, if appropriate. Services include child–parent psychotherapy, play therapy, individual therapy, family therapy, psychological assessment/testing, and psychiatric assessment/psychopharmacology evaluations. The goals of the outpatient clinic are to provide skilled, empathetic, and personalized mental health care to patients and families throughout the southeast region of Louisiana.

State licensure boards and reimbursement rules that vary from state to state govern pre-COVID-19 pandemic and current telehealth rules. Rules were quickly adjusted in the wake of nationwide stay-at-home orders with the 1135 Waiver expanding telehealth services. This expansion permitted at-home telehealth visits with equal reimbursement rates to in-person visits. Before the expansion, most outpatient services restricted patients/families “originating site” (patients/families’ location during the telehealth visit) to clinic offices, hospitals, and schools. Some telehealth services were also limited to designated underserved and rural areas for reimbursement. Telehealth providers were also required to use a HIPAA-compliant interactive audio and video telecommunication system that allowed real-time communication between providers and patients.

During the initial days of the COVID-19 pandemic, LSU BSC patients and families were rapidly moved to a web-based telehealth platform currently used by some providers in the clinic or national meeting/conference platforms that increased security measures to meet HIPAA compliance. Although telehealth platforms can be web-based programs or mobile apps, they can require a software download, installation, and sign-up via a smartphone or computer device. This process also requires access to reliable Internet and data plans. Patients and families were appropriately assessed for telehealth services and scheduled accordingly. Consents and authorizations were obtained verbally or through a computer, email, or fax system. Medication prescribing restrictions were lifted to allow electronic prescribing for all medications, including controlled substances. The multidisciplinary team of infant, child, and adolescent providers could refer, coordinate, and collaborate



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There continues to be a significant disparity in health care access related to race and socioeconomic status, and the added layer of technological inequity worsens that disparity.

care through conference/meeting platforms the same as before COVID-19. The majority of families were relieved at the options of ongoing services and support. For families with smartphones, computers, and reliable internet access and service, there were fewer technical issues transitioning to telehealth visits. The change in telehealth services allowed both continuity of care with established patients and acceptance of new patients via audio-visual connection during a very emotional and critical time for families adjusting to stay-at-home orders, distance learning, and economic instability.

The advantages of telehealth services are immense for outpatient services. Patients, families, and providers can maintain a working relationship even during the most restrictive phases of COVID-19. Both existing and new patient families have full access to all mental health disciplines and tools/assessments as appropriate. All caregivers can join a visit at different locations while completing a visit. And with the emergency expansion, providers and agencies will continue to receive reimbursement and funding for services provided.

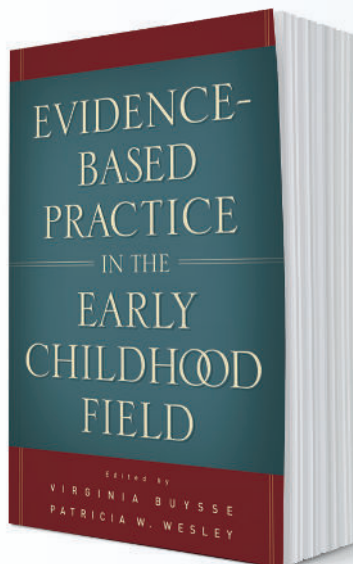
Some technical barriers of telehealth outpatient services are related to access to smartphones, computers, and Internet capabilities. Lack of multimedia devices and Internet capacity restricts services to audio-only. Although audio-only service is not an issue for established cases and is still reimbursable, audio-to-audio connection limits the ability to take on new cases during a much-needed time. For some areas, especially rural areas in Louisiana, there is less access and reliability of Internet connection. During this time, some clinical barriers included issues related to rapport building with new patients, shorter attention spans for younger patients, and an increase in

behavioral issues reported and witnessed while on screen. For medication providers, there was also an increased request to start or adjust medication during this time.

One major challenge for all providers and agencies providing outpatient services during the COVID-19 pandemic is addressing the effects of systemic inequity and ensuring inclusive and equitable care for all families. There continues to be a significant disparity in health care access related to race and socioeconomic status, and the added layer of technological inequity worsens that disparity. Ongoing assessment, planning, and advocacy are needed to decrease Internet access barriers, increase access to broadband/high-speed Internet, and decrease requirements to sign up or log in to telehealth platforms to ensure all families have access to mental health care during these unprecedented times.

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Dr. Mamon is a clinical assistant professor in the Department of Psychiatry at Louisiana State University (LSU) Health Science Center-New Orleans and currently serves as section chief of infant, child, and adolescent psychiatry. Dr. Mamon holds a bachelor of science degree in biology from Xavier University of Louisiana and a medical degree from the University of Nebraska Medical Center in Omaha, Nebraska. She completed her adult internship and residency at the LSU/Ochsner Adult Residency Program in New Orleans and completed an additional 2-year fellowship in child and adolescent training at LSU. She is also a trainee of the Harris Program for Infant Mental Health. Dr. Mamon has special interests in early childhood intervention and the impacts of systemic inequity on children and families. Dr. Mamon believes in working in collaboration while using a family-centered approach to strengthen relationships, promote development, and improve function from infancy into adolescence with various therapeutic interventions. Her greatest passion is teaching, speaking, learning, and engaging others in conversations about creating an inclusive and equitable society for all.



Evidence-Based Practice in the Early Childhood Field

Edited by Virginia Buysse and Patricia W. Wesley

Evidence-based practice is a common requirement for obtaining funding, and it can be a key element in providing high-quality services to young children and families.

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